No. 11180

IN THE

United States Circuit Court of Appeals

FOR THE NINTH CIRCUIT

HARRY LUTZ and HARRY LUTZ and ROSE LUTZ, as executor and executrix of the last will and testament of Abe Lutz, deceased,

Appellants,

vs.

NEW ENGLAND MUTUAL LIFE INSURANCE COMPANY OF BOSTON, a corporation,

Appellee.

Upon Appeal from the District Court of the United States for the Southern District of California, Central Division.

APPELLEE'S BRIEF.

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APPELLEE'S BRIEF.

Statement of the Case.

This action was brought by appellee, a life insurance company, to rescind and cancel a certain policy of life insurance insuring the life of one Abe Lutz, hereinafter referred to as the "insured" [R. 2 to 21]. Appellee's amended complaint alleged in substance that matters of fact relating to the health and medical history of the insured, and material to the risk insured against, were misrepresented and concealed in the application for said policy [R. 6 *et seq.*]. It was further alleged in the amended complaint that the insured was not in good

health, either at the time said application was approved by appellee or at the time the first premium was paid by appellant, and that, by reason of said fact, the policy, according to its terms, never became effective [R. 14, 15].

After a trial on the merits, the court below made findings of fact sustaining all the material allegations of appellee's amended complaint [R. 49 to 61]. The court further found, contrary to the contentions of appellant, that appellee had not waived, and was not estopped to assert, its right to rescind and cancel the policy [R. 56 to 59].

Upon these findings, the trial court concluded that appellee was justified in rescinding and cancelling the policy and, further, that, by reason of the fact that the insured was not in good health when the application for the policy was approved and when the first premium thereon was paid, the policy, by its terms, failed to become effective [R. 60, 61]. Judgment was accordingly rendered, declaring the rescission and cancellation of the policy and denying appellant any recovery thereon [R. 62, 63]. Reference to the record discloses the abundant sufficiency of the evidence to sustain the findings of the District Court.

On November 14, 1942, Abe Lutz, as "Proposed Insured," and appellant Harry Lutz, as "Applicant for Insurance," signed Part I of an application to appellee for the issuance of a policy of ordinary life insurance in the amount of $13,000.00 upon the life of said Abe Lutz, said insurance to be payable to appellant, whose relationship to the insured was stated to be that of a son. Part I of the application is designed to elicit information as to the place of residence, age and occupation of the proposed insured, the amount and form of insurance applied for,

the name of the proposed beneficiary, etc. Part I of the application contains the following provision:

> "It is Hereby Agreed that this Application, including Part II, a copy of which shall be attached to the Policy when Issued, shall become a part of every Policy issued hereon; that acceptance of a Policy shall constitute ratification of any and all changes noted by the Company under 'Additions and Amendments,' and that the insurance applied for shall not take effect unless and until this Application is approved by the Company at its Home Office and the first premium is paid while the Proposed Insured is in good health; provided that subsequent premiums shall be due and subsequent policy years begin as shown on the first page of the Policy. If, however, the first premium is paid with this Application, and it is so stated in answer to Question 24, the insurance shall take effect as stipulated in the Conditional Receipt." [R. 392.]

On November 16, 1942, the insured submitted to a physical examination by appellee's medical examiner, and then and there signed Part II of the application for said policy, which sets forth the questions propounded by the medical examiner concerning the health and medical history of the proposed insured and the answers of the latter in response to said questions [R. 393]. The following questions and answers, among others, appear:

"29. What illnesses, diseases or injuries have you had since childhood? Describe fully.

Name of disease	*Date of attack*	*Duration*	*Severity*	*Results*
Influenza	*1918*	*2 weeks*	*Mild*	*Good*
Slight colds occasionally	*None for 1 year*		*Mild*	*Good*

* * * * * * *

35. Have you ever suffered from: (Give details under 44)
    A. Indigestion? *No.*
    B. Insomnia? *No.*
    C. Nervous strain or depression? *No.*
    D. Overwork? *No.*
    E. Dizziness or fainting spells? *No.*
    F. Palpitation of heart? *No.*
    G. Shortness of breath? *No.*
    H. Pain or pressure in the chest? *No.*

36. A. Have you consulted, or been examined by, a physician or other practitioner within five years? *Yes.*
    B. If so, give reasons, name of practitioner and details under 44.

* * * * * * *

44. Special Information:
    36. *Dr. Maurice H. Rosenfeld, 1908, August 1942, Physical examination and blood sugar determination—report was normal.*
    30. *Tonsils were slightly enlarged previous to tonsilectomy—1930—good results."*

It will be observed that the insured, by his answers to the questions contained in the application, specifically denied that he had ever suffered from indigestion, nervous strain or depression, dizziness or fainting spells, palpitation of the heart, shortness of breath or pain or pressure in the chest. Question number 36 inquired whether insured had consulted, or been examined by, a physician within five years, and, if so, required the giving of reasons, name of practitioner and details. In response to this question, the insured disclosed that he had consulted

Dr. Maurice H. Rosenfeld in August, 1942, for physical examination and blood sugar determination, stating that "report was normal."

Below the above stated questions and answers, and immediately above the signature of the proposed insured, the following statement appears:

> "I certify that I have read my answers to the foregoing questions, that they are true and complete, and that they are correctly recorded. I expressly waive to such extent as may be lawful, on behalf of myself and of any other person who shall have or claim any interest in any policy issued hereunder, all provisions of law forbidding any physician or other person who has attended or examined me, or who may hereafter attend or examine me, from disclosing any knowledge or information which he thereby acquired, and I authorize any such disclosure." [R. 393.]

On December 1, 1942, appellee issued the policy in suit in the amount of $13,000.00 [R. 39 to 46]. Said policy recites on its face that it is issued "in consideration of the application" and of the annual premium therein provided to be paid. The policy contains, among others, the following provision under the sub-title "CONTRACT":

> "This Policy and the application, a copy of which is attached to and made a part of this policy, constitute the entire contract between the parties. All statements made by the Insured or in his behalf, in the absence of fraud, shall be deemed representations and not warranties; and no such statement shall be used in defense to a claim unless contained in the application and unless a copy of such application is attached to this Policy when issued. No endorsement or alteration of this Policy and no waiver of

any of its provisions shall be valid unless made in writing by the Company and signed by its President, Vice-President, Secretary, Assistant Secretary or Registrar; and no other person shall have authority to bind the Company in any manner." [R. 41.]

A photostatic copy of the application was attached to the original of the policy [R. 44]. The policy was delivered to appellant Harry Lutz at Los Angeles, California, on or about December 9, 1942, at which time the first annual premium was paid [R. 384].

The insured died on May 28, 1944, that is, approximately seventeen months after the date of the issuance of the policy. In the death certificate filed with the Bureau of Vital Statistics, the causes of death were stated to be acute coronary thrombosis, angina pectoris and duodenal ulcer [R. 420].

Subsequent to receipt of the proofs of death, appellee instituted an investigation which lead to the discovery that material facts concerning the medical history and state of health of the insured had been concealed and misrepresented in the application [R. 297].

One of the witnesses called by appellee at the trial was Stephen G. Seech, a physician and surgeon specializing in ophthalmology. This physician testified that he was consulted by the insured on January 15, 1937 [R. 155], at which time the insured informed the doctor that he had been suffering from dizziness and nausea [R. 156]. The doctor testified that he examined the insured's eyes with an ophthalmoscope and found "several very tortuous vessels * * * and a few punctuate hemorrhages" [R. 156]. The doctor testified that the hemorrhages could indicate several conditions, including diabetes, per-

nicious anemia and arteriosclerosis [R. 160]. At the time of the first consultation, Dr. Seech gave the insured a prescription for phenobarbital tablets, the purpose of which was "to quiet the apprehension of the patient" [R. 162].

At the time of a second consultation in October, 1937, Dr. Seech gave the insured a prescription for saturate solution of potassium iodine, the purpose of which was "to hasten the absorption of blood" [R. 163]. On the occasion of a third consultation with Dr. Seech on May 21, 1938, the insured again complained of dizziness [R. 161].

Appellee also called as a witness Dr. Maurice H. Rosenfeld, a physician specializing in diseases of the heart [R. 98]. Dr. Rosenfeld testified that he was first consulted by the insured on January 16, 1937, the patient having been referred to him by a Dr. Polesky [R. 101].

On the occasion of the first consultation, the insured complained to Dr. Rosenfeld "of dizziness and inability to arise the week before the examination of January 16, 1937" [R. 102]. The doctor made a complete physical examination and laboratory study, and took an electrocardiograph. Dr. Rosenfeld testified that he thereupon made a diagnosis of "probable slight stroke," and that he found evidence of arteriosclerosis, or hardening of the arteries, a disease which he stated was "progressive and chronic" [R. 103]. Dr. Rosenfeld further testified:

> "I advised the patient that he had a mild stroke, in that he had symptoms which were suggestive and that, together with the report by an eye specialist who I had seen, suggested this condition, and for that reason I advised him of this possible diagnosis." [R. 104.]

The insured again consulted Dr. Rosenfeld on June 1, 1942, complaining that on excitement, strain or effort, he was subject to pain in the heart region [R. 104]. After the consultation of June 1, 1942, and after studying the electrocardiograph taken on that date, Dr. Rosenfeld made a diagnosis of probable angina pectoris, due to narrowing of the coronary artery. Dr. Rosenfeld advised the insured to curtail his activities, and gave him a prescription of nitroglycerine tablets for relief of the pain of angina pectoris, which the doctor described as an acute pain referable to the heart region [R. 106].

The insured went to the office of Dr. Rosenfeld for further examinations and for the taking of electrocardiographs on June 3, June 5, June 12, July 6, August 7 and August 11 of 1942. On each of these several occasions, the doctor told the insured "that in view of the fact that he was subject to pain around his heart that occurs after exercise or effort or after emotion, together with the minor changes noted in the electrocardiogram, that it was my opinion that these were due to a condition known as angina pectoris" [R. 117].

Dr. Rosenfeld testified that angina pectoris, caused by the narrowing of the coronary artery, was "a chronic disease manifested by an acute exacerbation of pain" [R. 119]; that "the condition that was the actual cause of death was just a continuation of the process of angina pectoris" [R. 121]; and that the insured was suffering from arteriosclerosis and angina pectoris during the period from June 1, 1942, to December 9, 1942 [R. 120 to 123].

Appellee called as a witness one H. C. Ludden, a pharmacist, who testified that he had known Mr. Lutz, the insured, for some twenty years [R. 81]; and that on

June 1, 1942, the witness, at the request of the insured, filled a certain prescription for nitroglycerine tablets [R. 83]. This prescription, which had been given the insured by Dr. Rosenfeld, is in evidence as Plaintiff's Exhibit No. 7 [R. 401]. The direction written on the prescription is as follows: "Sig.—Dissolve one tablet under tongue for heart pain." With reference to his discussion with the insured on June 1, 1942, Mr. Ludden testified further as follows:

"Q. On that occasion, Mr. Ludden, did Mr. Lutz express to you anything to the effect that he was suffering from any pain or illness? A. Mr. Lutz came in and simply handed me the prescription, and made the remark that he did have a pain in his chest, and would like to have the prescription as soon as possible.

Q. Did you have occasion to refill the prescription for nitroglycerine, which has been identified as Plaintiff's Exhibit No. 7 for identification? A. Many times.

Q. How many times would you estimate, Mr. Ludden, did you refill the prescription which is Plaintiff's Exhibit No. 7 for identification, between June 1, 1942, and October 31, 1942, if you can estimate it? A. That would be pretty hard to state.

Q. Would you say as much as twice? A. I would say about four times." [R. 88.]

* * * * * * * * *

"Q. Please read to us the part or parts, if any, on that exhibit, which is Plaintiff's Exhibit No. 7, which you placed on the bottle. A. The words: Prescription No. 89543. Dr. M. H. Rosenfeld. Dissolve one tablet under tongue for heart pain. Mr. Lutz. 6-1-42.

Q. Do I understand that that portion of the exhibit which you have just read was placed by you on the label of the bottle? A. Yes, sir." [R. 94.]

The foregoing summary of the evidence suffices to demonstrate the substantial foundation upon which the findings of the District Court are based. These findings include the following:

"That in and by said application for said policy of insurance, said Abe Lutz, insured, represented to plaintiff company that said Abe Lutz had never suffered from indigestion, dizziness or fainting spells, palpitation of the heart or pain or pressure in the chest. That said representations were false and were known by said insured to be false at the time said application was made and signed; that prior to the time that said application for insurance was made and signed, said insured had suffered from indigestion, dizziness and fainting spells and from pain in the chest." [Finding No. IX, R. 52.]

"That in and by said application for insurance, the insured was asked whether he had consulted or been examined by a physician or other practitioner within five years prior to the date thereof, and, if so, to give reasons, name of practitioner and details with reference thereto. That in response to said questions, the insured disclosed no information except that he had consulted Dr. Maurice H. Rosenfeld in August, 1942, and was given at that time a physical examination and blood sugar determination; and insured represented that the report of said examination was normal." [Finding No. X, R. 52.]

"That, within five years prior to the date of said application, said insured had consulted, and had been examined by, physicians at times other than in

August, 1942; that within five years prior to the date of said application for insurance, said insured had consulted and been treated by physicians for dizziness and fainting spells and for pain in the chest. That during the year 1942 and prior to the date of the application for said insurance, said insured, on numerous occasions, had consulted and been examined by a physician and had received treatments for angina pectoris, a disease of the heart. That during the year 1942 and prior to the date of the application for said policy of insurance, said insured had submitted to repeated physical examinations which included the taking of electrocardiograms and had been told by his physician that he was suffering from a heart ailment, to-wit, angina pectoris, and that he should curtail and limit his activities by reason thereof; that during the year 1942 and prior to the date of the application for said policy of insurance, said insured's physician had prescribed medicine to relieve pain in the chest suffered by insured as a result of said heart ailment. That all of the facts in this paragraph recited were concealed, and none of them was disclosed, in the application for said policy of insurance." [Finding No. XI, R. 52, 53.]

"That all of the facts concerning the health and medical history of said insured which were misrepresented and concealed in the application for said policy of insurance, as herein found, were known to the insured at the time said application was made and signed, and said facts were material to the risk insured against under the terms of said policy." [Finding No. XII, R. 53.]

"That it was, and is, provided by the terms of said policy of life insurance and of the application therefor that said policy should not take effect unless and

until said application should be approved by plaintiff at its home office and the first premium paid while the said insured was in good health. That said insured was not in good health at the time said policy was delivered, or at the time the first premium thereon was paid. That said insured knew, at the time said application for insurance was signed and delivered and at the time said policy was issued and delivered, and at the time the first premium thereon was paid, that he was not in good health, but that he was suffering from a serious disease of the heart, to-wit, angina pectoris." [Finding No. XIX, R. 56.]

POINT I.

Concealment or Misrepresentation of a Material Fact in an Application for Insurance Entitles the Insurer to Rescind, Regardless of Whether the Concealment or Misrepresentation Was Intentional or Unintentional.

The policy in suit was applied for and delivered, and the premiums thereon were paid, in California. It is therefore a California contract, so that the substantive law of California is applicable and controlling.

Equitable Life Assurance Society v. Pettus, 140 U. S. 226, 11 S. Ct. 822, 35 L. Ed. 497;

Gates v. General Casualty Co. of America, 120 F. (2d) 925, 926;

Palmquist v. Standard Accident Ins. Co., 3 F. Supp. 356, 357.

The California law is well settled that a false representation, or the concealment of a material fact, in an application for a policy of insurance, *whether intentional or unintentional,* vitiates the policy. Fraudulent intent is

not an essential element of a cause of action for rescission of an insurance contract.

Gates v. General Casualty Co. of America, 120 F. (2d) 925, 926;

California Western States Life Ins. Co. v. Feinstein, 15 Cal. (2d) 413, 101 P. (2d) 696;

Telford v. New York Life Ins. Co., 9 Cal. (2d) 103, 69 P. (2d) 835;

Maggini v. West Coast Life Ins. Co., 136 Cal. App. 472, 29 P. (2d) 263.

In *Telford v. New York Life Ins. Co., supra,* the Supreme Court of California said:

> "A false representation or a concealment of fact, whether intentional or unintentional, which is material to the risk vitiates the policy. The presence of an intent to deceive is not essential."

In *Gates v. General Casualty Co. of America,* 120 F. (2d) 925, at page 927, this court stated and applied the same rule, quoting with approval from the decision in *Telford v. New York Life Ins. Co., supra.*

The California Insurance Code, in the article headed "CONCEALMENT," contains the following provisions:

> "§330. Definition. Neglect to communicate that which a party knows, and ought to communicate, is concealment.
>
> "§331. Effect. Concealment, whether intentional or unintentional, entitles the injured party to rescind insurance."

The same code, in the article headed "REPRESENTATION," contains the following provisions:

> "§358. Falsity. A representation is false when the facts fail to correspond with its assertions or stipulations.
>
> "§359. Effect of falsity. If a representation is false in a material point, whether affirmative or promissory, the injured party is entitled to rescind the contract from the time the representation becomes false."

Appellant argues (1) that the insured was not a party to the insurance contract, (2) that the only contracting parties were appellee, as insurer, and appellant, as beneficiary and owner of the policy, and (3) that the policy does not provide, either expressly or by implication, that appellant's rights under the contract are dependent upon, or affected by, the conduct of the insured or the truth or falsity of the statements of the insured as contained in the application. Upon these premises, appellant predicates his argument that the contract in suit is not vitiated by any concealment or misrepresentation of facts in the application for the policy.

Appellee submits that appellant's argument is fallacious both in its premises and in its conclusion.

Part I of the application for the policy involved in this case was signed by appellant as *"Applicant for Insurance,"* and by Abe Lutz as *"Proposed Insured"* [R. 405]. Immediately above the signatures of appellant and the insured, the following language appears upon Part I of the application:

> *"It is Hereby Agreed that this Application, including Part II, a copy of which shall be attached to the*

*Policy when issued, shall become a part of every Policy issued hereon; * * *."*

Under the heading "CONTRACT," the policy provides as follows:

> *"This Policy and the application, a copy of which is attached to and made a part of this Policy, constitute the entire contract between the parties. All statements made by the Insured or in his behalf, in the absence of fraud, shall be deemed representations and not warranties; and no such statement shall be used in defense to a claim unless contained in the application and unless a copy of such application is attached to this Policy when issued. * * *"* [R. 41.]

Moreover, on its first page, the policy recites that *"This Policy is issued in consideration of the application and of the annual premium * * *."* [R. 39.]

By the plainest of language, the parties to the contract agreed that the application, including both Parts I and II, would be and become a part of the policy, and that *"all statements made by the Insured or in his behalf, in the absence of fraud, shall be deemed representations and not warranties."*

Appellant may deny the existence of a fraudulent intent on his part, but he cannot be heard to deny that the statements of the insured, as contained in the application, constituted representations. By the plain terms of the contract, appellant *adopted* as his own the statements of the insured, as set forth in the application, and agreed that they should be made a part of the contract. He further agreed that the statements of the insured should be deemed *representations,* or in the presence of fraud, *warranties.*

It is immaterial whether appellant or the insured *intended* to deceive or defraud the insurance company. It is sufficient to vitiate the policy if it be proved that a false or erroneous representation was made, either intentionally or unintentionally, as to any material fact *(Telford v. New York Life Ins. Co., supra).* The California statute plainly states that *"a representation is false when the facts fail to correspond with its assertions or stipulations."* (*California Insurance Code,* Sec. 358.)

Clearly, the well supported findings of the District Court that matters of fact, material to the risk, were misrepresented and concealed in the application suffice to sustain the judgment under review.

POINT II.

Answers to Written Questions Set Forth in an Application for Insurance Constitute Material Representations as a Matter of Law.

The California law is well settled that answers to written questions set forth in application forms relative to insurance contracts are *deemed* material as a matter of law.

California Western States etc. v. Feinstein, 15 Cal. (2d) 413, 101 P. (2d) 696;

Pierre v. Metropolitan Life Ins. Co., 22 Cal. App. (2d) 346, 70 P. (2d) 985;

Inverson v. Metropolitan Life Ins. Co., 151 Cal. App. 746, 91 Pac. 609;

Westphall v. Metropolitan Iife Ins. Co., 27 Cal. App. 734, 151 Pac. 159;

McEwen v. New York Life Ins. Co., 42 Cal. App. 133, 146, 183 Pac. 373;

Maggini v. West Coast Life Ins. Co., 136 Cal. App. 472, 29 P. (2d) 263;

Layton v. New York Life Ins. Co., 55 Cal. App. 202, 202 Pac. 958.

In *California Western States etc. Co. v. Feinstein, supra,* the California Supreme Court said:

> "It has been held that answers to written questions set forth in application forms relative to insurance are generally *deemed* material representations." (Citing many cases.)

In *Maggini v. West Coast Life Ins. Co., supra,* it was stated:

> "The materiality of the representations cannot be doubted, these being in the form of written answers made to written questions which the parties themselves thus indicated they deemed material."

In *Pierre v. Metropolitan Life Ins. Co., supra,* we find the following expressions:

> "Answers to questions in an application are generally considered to be material representations of fact, which if false will vitiate the contract * * * an answer to a question as to whether an applicant had ever had a specified disease is material and, if false, avoids the policy * * *."

The foregoing authorities clearly show that appellee's right to rescind was fully and completely established by proof that matters of fact relating to the health, physical condition and medical history of the insured were falsely represented in the application. In other words, the facts concealed and misrepresented by the insured in the instant case were, necessarily and as a matter of law, material.

POINT III.

The Policy in Suit Never Became Effective Because the Insured Was Not in Good Health When the Application for the Policy Was Approved and When the First Premium Thereon Was Paid.

As we have seen, the District Court found, upon substantial and uncontradicted evidence, that the insured was not in good health at the time the application for the policy in suit was approved or at the time when the first premium was paid, but was suffering from a serious disease of the heart, to-wit, angina pectoris. This finding was supported by evidence that prior to the date of the application, the insured had suffered a stroke, and by the testimony of Dr. Rosenfeld that during the period from June 1, 1942, to December 9, 1942, the insured was suffering from arteriosclerosis and angina pectoris, diseases which were immediately contributing causes of the insured's death. Under these circumstances, the following provision of the contract is of decisive effect:

> "* * * *that the insurance applied for shall not take effect unless and until this Application is approved by the Company at its Home office and the first premium is paid while the Proposed Insured is in good health;* * * *."

Referring to an almost identical clause in deciding a case involving a factual situation strikingly similar to the case at bar, the Circuit Court of Appeals for the Eighth Circuit used the following language in *Gill v. Mutual Life Ins. Co. of N. Y.*, 63 F. (2d) 967, at page 970:

> "* * * It is well settled that this clause in that contract, which provides that a policy shall not become effective unless delivered and received while the

insured is in good health, is valid and will be enforced; * * *."

The foregoing quotation is followed in the text by the citation of a long list of supporting decisions. (Accord, see 4 *Couch Cyclopedia of Insurance Law,* Sec. 860, p. 2828.)

The validity and effectiveness of similar provisions creating conditions precedent were sustained in:

Stipcich v. Metropolitan Life Ins. Co., 277 U. S. 311, 48 S. Ct. 512, 72 L. Ed. 895;

New York Life Ins. Co. v. Gist, 63 F. (2d) 732, 735;

Shaner v. West Coast Life Ins. Co., 73 F. (2d) 681, 685;

Greenbaum v. Columbian National Life Ins. Co., 62 F. (2d) 56;

Continental Illinois Natl. Bank & Trust Co. v. Columbian Natl. Life Ins. Co., 76 F. (2d) 733;

Hurt v. New York Life Ins. Co., 51 F. (2d) 936;

New York Life Ins. Co. v. Gay, 36 F. (2d) 634, 636, 48 F. (2d) 595;

Pierre v. Metropolitan Life Ins. Co., 22 Cal. App. (2d) 346, 70 P. (2d) 985;

Security Life Ins. Co. v. Booms, 31 Cal. App. 119, 159 Pac. 1000.

Whether the non-fulfillment of the condition precedent to the effectiveness of the policy be regarded as affording appellee an additional ground for rescission, or whether it be considered only as a defense to appellant's counterclaim seeking recovery on the contract, it is, in either aspect, independently sufficient to sustain the judgment under review.

POINT IV.

Answers to Questions Propounded to the Proposed Insured in an Application for Insurance Are Representations Upon Which the Insurer Is Entitled to Rely, and the Insurer Is Under No Duty to Make an Investigation to Determine the Truth of Such Answers.

Appellant here contends that since the application disclosed the name of a physician from whom appellee might have learned facts at variance with the representations of the application, appellee is estopped to rely upon such representations. In other words, appellant argues that appellee was under a duty to investigate and make inquiry in order to ascertain whether or not the statements of fact contained in the application were true.

A complete answer to appellant's arguments on this aspect of the case is to be found in the opinion of this court in *Gates v. General Casualty Co. of America,* 120 F. (2d) 925, which cites and quotes at length from the California decisions. It discusses and distinguishes the case of *Turner v. Redwood Mutual Life Assn.,* 13 Cal. App. (2d) 573, 57 P. (2d) 222, upon which appellant so strongly relies in the instant case.

The insufficiency of the matters relied upon by appellant to spell out waiver or estoppel is demonstrated by reference to the California decisions cited in *Gates v. General Casualty Co. of America, supra,* and particularly the following:

Telford v. New York life Ins. Co., 9 Cal. (2d) 103, 69 P. (2d) 835;

Frederick v. Federal Life Ins. Co., 13 Cal. App. (2d) 585, 57 P. (2d) 235;

Maggini v. West Coast Life Ins. Co., 136 Cal. App. 472, 29 P. (2d) 263.

In each of the cases last cited, facts were known to the insurer, at the time it acted upon the application involved, which tended to indicate incorrectness or incompleteness of certain answers therein contained. In each case, it was held that the insurer was not estopped to rescind upon discovering the falsity of material representations upon which it was entitled to rely. The following language from *Frederick v. Federal Life Ins. Co., supra,* is particularly applicable:

> "* * * Even if it be considered that defendant upon receipt of the medical examiner's report, had knowledge that, as regards the treatment by Dr. Woods, plaintiff had not fully answered the questions in the application, it does not follow that defendant cannot resist recovery on the policy on account of other and serious representations which defendant thereafter learned to be false. The application and report of the medical examiner were forwarded to company headquarters where the officials of defendant company decided whether they cared to issue the policy. It was their right to reject the application if upon the information before them they desired to do so. The fact that they might have overlooked or considered as inconsequential an incorrect or incomplete answer contained in the application does not prevent their defense against fraudulent statements, the falsity of which was discovered after the issuance of the policy. The defendant had no knowledge at the time the policy was issued of the misrepresentations now relied upon to defeat recovery."

In *Maggini v. West Coast Life Ins. Co.,* 136 Cal. App. 472, 29 P. (2d) 263, the court stated:

> "But the evidence is clear that the appellant did not have any knowledge of the falsity of any of these misrepresentations except that relating to the illness of the insured five years prior to the date of the policies. This may have been sufficient to raise a suspicion as to the truth of other representations relied on; but cause for suspicion does not constitute knowledge. Hence there could be no estoppel of the insurer's right to 'set up the fraud by way of defense to an action brought to enforce the apparent liability.' (*California Reclamation Co. v. New Zealand Ins. Co.,* 23 Cal. App. 611, 615 (138 Pac. 960, 961); *General Accident, Fire & Life Assur. Corp. v. Industrial Acc. Com.,* 196 Cal. 179, 189, 190 (237 Pac. 33).)"

It is the well settled rule in California that the mere fact that a defrauded party may have had a means of acquiring knowledge of the truth does not debar recovery, there being no duty to investigate. The rule was recently stated in *Twining v. Thompson,* 68 Cal. App. (2d) 104, 156 P. (2d) 29, as follows:

> "Where there is no legal duty of a plaintiff to investigate and no such circumstance is present as would put a reasonably prudent man upon inquiry, the mere fact that a means of acquiring knowledge is available to plaintiff and he has not made use of such means does not debar plaintiff from recovering after he makes the discovery. (*Tarke v. Bingham,* 123 Cal. 163, 166 (55 P. 759).) Innocent parties do not carry the burden of inquiry. (*Hart v. Walton,* 9 Cal. App. 502, 509 (99 P. 719).)"

Appellant offered no evidence whatsoever in the case at bar which proved, or tended to prove, that the insurer had knowledge of the falsity of any material representation concerning the health or medical history of the insured. The nearest approach to a circumstance which might have cast suspicion upon the completeness and truthfulness of insured's answers was the fact that appellee had information indicating that insured had, at some time or other, consulted a Dr. Lissner, who was an associate of Dr. Rosenfeld. It appears, however, that appellee had no knowledge concerning the date or the purpose of the supposed consultation with Dr. Lissner.

Appellant urges that appellee is estopped to assert that it relied upon the representations of the insured concerning his health and medical history by reason of the fact that Dr. Waste, the insurer's medical examiner, examined the insured and made a report indicating a favorable opinion as to his insurability. This contention is clearly without merit. In the first place, the requirement of medical examinations in connection with applications for life insurance is practically universal. In nearly every cited case dealing with concealment and misrepresentation in connection with an application for life insurance, it appears that the insured had submitted to a medical examination and that a report of such examination was received and considered by the insurer in connection with the application. It is manifest that such fact affords no basis for claim of waiver or estoppel.

In the second place, it is a matter of universal knowledge, affording a basis for judicial notice, that a great many serious diseases and ailments, including diseases of the heart and circulatory system, are latent, and may not be disclosed objectively even upon the most careful physi-

cal examination. Indeed, Dr. Waste so testified in this case [R. 223, 224]. It is in recognition of this obvious truth that the courts have uniformly held that insurance companies are entitled to receive full, complete and truthful answers from the insured concerning his health, medical history, past complaints and ailments.

POINT V.

There Can Be No Waiver of the Insurer's Right to Rescind Upon Grounds of Misrepresentation and Concealment Until After the Insurer Has Become Aware of the Falsity of the Representations.

The defenses of estoppel and waiver asserted by appellant herein are closely related. Accordingly, the decision in *Gates v. General Casualty Co. of America,* 120 F. (2d) 925, and the cases therein cited are also pertinent to the defense of waiver.

It is, of course, well settled that a party asserting affirmative defenses of waiver and estoppel bears the burden of proving such defenses by clear and convincing evidence. (8 *Couch Cyclopedia of Insurance Law,* Sec. 2238, p. 7281.)

And in the case of *California Western States etc. Co. v. Feinstein,* 15 Cal. (2d) 413 at p. 422, 101 P. (2d) 696 at 701, it is stated:

> "Nor may it be said that the insurer could have waived its right to rescind, on the ground of false representations made by the insured in his answers to the questions as set forth in the application for reinstatement, until the insurer had become aware of the falsity of those representations. (*McDanels v. General Ins. Co., supra; Schick v. Equitable Life Assur. Soc.,* 15 Cal. App. (2d) 28, 34 (59 Pac. (2d)

163).) It was only after the insured had filed his claim for disability payments in June, 1936, at which time an investigation was made with regard to the ailments for which he had undergone treatment by a physician, that the falsity of the representations which the insured had made in the application for reinstatement was disclosed. On that state of the record it cannot be said that the insurer had waived any of the rights which it subsequently asserted against the insured."

In *Schick v. Equitable Life Assur. Soc.,* 15 Cal. App. (2d) 28, at page 34, the following from 67 C. J. 310, is quoted with approval:

> "The evidence must show knowledge, at the time the waiver is claimed to have occurred, of all the material facts that would probably have influenced the conduct of the party; the proof must be clear that the party against whom the doctrine of waiver is invoked knew what his rights were. A waiver cannot be established by a consent given under a mistake of fact."

Appellant's affirmative defenses of waiver and estoppel necessarily failed because he did not sustain his burden of proving them and because the uncontradicted evidence established that the insurer received no knowledge or information whatever concerning the matters misrepresented and concealed until after investigation was made subsequent to the death of the insured. The insured's death occurring so soon after the issuance of the policy and from the causes indicated by the death certificate naturally suggested the propriety of such investigation.

POINT VI.

The Insured Having Executed an Express Waiver of the Physician-Patient Privilege, the Trial Court Did Not Err in Admitting the Testimony of Physicians Who Had Been Consulted by the Insured.

Appellee submits that appellant's brief does not properly specify the errors relied upon in the manner required by Rule 20(d) of the rules of this court, especially with reference to alleged errors in the admission of evidence. Appellant has failed to quote either the grounds of objection urged at the trial or the substance of the evidence admitted. Moreover, the specifications of error are not limited to the scope of the statement of points served and filed pursuant to Rule 75(d) of the Federal Rules of Civil Procedure and set forth in the appendix to appellant's opening brief. Nevertheless, appellee will show that the contentions made by appellant are without merit.

The insurer called two physicians, who testified that they had been consulted by the insured prior to the date of the application for the policy in suit. The testimony of these witnesses proved, or tended to prove: (1) That prior to the date of the application, insured (a) had suffered from, and complained of, dizziness, nausea and pain in the chest, (b) had been taking nitroglycerine tablets prescribed for the relief of heart pain, (c) had suffered a slight stroke which had rendered him unable to rise from his bed for a week, (d) had submitted to numerous physical examinations in which electrocardiographs were taken; and (2) that from a time anterior to the application to the date of his death, insured had suffered from arteriosclerosis and angina pectoris, which were serious, chronic and progressive diseases of the circulatory system

and which contributed as immediate causes of insured's death.

Appellant argues that the trial court erred in overruling objections to this testimony made upon the ground that it related to privileged matters concerning which the physicians could not properly be examined by virtue of the provisions of Section 1881, subdivision (4) of the California Code of Civil Procedure. This statute provides in part that "a licensed physician or surgeon can not, *without the consent of his patient,* be examined in a civil action as to any information acquired in attending the patient, which was necessary to enable him to prescribe or act for the patient; * * *." (Italics supplied.) The prohibition of the statute is subject to a number of qualifications and exceptions which need not be noted here.

It is undisputed in this case that the insured executed Part II of the application containing the following provision:

> "* * * I expressly waive to such extent as may be lawful, on behalf of myself and of any person who shall have or claim any interest in any policy issued hereunder, all provisions of law forbidding any physician or other person who has attended or examined me, or who may hereafter attend or examine me, from disclosing any knowledge or information which he thereby acquired, and I authorize any such disclosure."

By the quoted language, the consent of the *patient* was unequivocally given. It thus appears that *appellant,* as beneficiary of the policy in suit, sought to assert a privilege which was personal to the insured and which the

insured had expressly waived. It is well settled law that the privilege is effectively waived by a provision to that effect in an application for insurance.

8 *Wigmore on Evidence,* 3rd Ed., §2388, p. 831;

70 *Corpus Juris,* §633, p. 466;

27 *Cal. Jur.,* §43, p. 59;

Wirthlin v. Mutual Life Ins. Co., 56 F. (2d) 137;

Lincoln National Life Ins. Co. v. Hammer, 41 F. (2d) 12;

New York Life Ins. Co. v. Renault, 11 F. (2d) 281.

Wigmore expresses the rule as follows:

> "(b) An *express waiver* by *contract, e. g.,* in a policy of insurance, may be given effect, on the general principle already noticed in §7a. Since experience has shown that the testimony of physicians who might assist the discovery of the truth is likely to be suppressed by the insured's claim of privilege, and since the contract of insurance is a voluntary transaction for both parties, the insurer's insistence on a provision of this sort in his contract is no more than a reasonable measure of self-protection, and does not affect the interest of patients in general other than the insured party to the contract."

Appellant apparently does not deny the validity or the effectiveness of an express waiver of the privilege such as was signed by the insured in this case. No decision cited by appellant holds or intimates that such a waiver is not valid and effective.

However, it appears to be appellant's contention that the insured's express waiver of the privilege became an integral part of the contract, and that the insurer's rescission of the contract operated to destroy the effectiveness of the waiver.

This novel and ingenious argument lacks the support of reason or authority. The rule that a party may not rescind a contract and, at the same time, claim benefits under it has no application here. Appellee seeks no benefit and asserts no substantive right which is not entirely consistent with its rescission and repudiation of the contract.

Rather, it is appellant who, with obvious inconsistency, has sought to *recover* upon the contract and, at the same time, to repudiate a waiver which he, himself, describes as an "integral part" of the contract.

We are dealing here, not with a rule of substantive law, but with a rule of evidence. Under the provisions of Rule 43(a) of the Federal Rules of Civil Procedure, *"the statute or rule which favors the reception of evidence governs,"* and it is important to note the further provision of the rule that *"the competency of a witness to testify shall be determined in like manner."*

Manifestly, the testimony of these physicians concerning their observations of the insured, their objective findings and their diagnoses was not hearsay. The declarations of the insured concerning his pains, complaints and suffering not only were a part of the *res gestae,* but also

were admissible under another recognized exception to the hearsay rule which is stated by *Wigmore* as follows:

> "It is for statements of physical pain or suffering that the exception has been longest recognized and the principle most fully and clearly reasoned out." (*Wigmore on Evidence* (3rd Ed.), Vol. VI, Secs. 17, 18, p. 63.)

Moreover, the insured's declarations were admissible to prove his knowledge of material facts concerning his health, which facts were fully established by other evidence. (*Missouri State Life Ins. Co. v. Young,* 38 F. (2d) 399; *Wigmore on Evidence* (3rd Ed.), Vol. II, Sec. 266(a), p. 91.)

Indeed, appellant limited his objections to disclosures made subsequent to the date of the application [R. 100], recognizing the admissibility of declarations and disclosures anterior thereto. Furthermore, the record shows that appellant, himself, expressly and in writing, authorized the disclosure of all the information which he now claims was privileged [R. 403, 404]. The record further shows that these authorizations executed by appellant were received by third parties and were used to obtain all of the information which appellant claims to be privileged [R. 231 *et seq.;* also, 240 *et seq.*]. Under these circumstances, appellant is estopped to assert any objection to the testimony of these physicians on the ground of privilege.

Estate of Visaxis, 95 Cal. App. 617, 273 Pac. 165.

POINT VII.

Appellant Has Wholly Failed to Sustain His Burden of Showing Error in the Findings of the District Court.

Appellant, of course, carries the burden of showing this appellate court that the findings of the District Court are clearly erroneous.

F. R. C. P., Rule 52(a);

Augustine v. Bowles, 149 F. (2d) 93, 96;

Gates v. General Casualty Co. of America, 120 F. (2d) 925, 929.

Appellee has shown by reference to the record that every finding of the trial court is supported by an abundance of substantial evidence. Indeed, the findings that material facts were falsely represented and concealed and the finding that insured was not in good health were required by uncontradicted evidence.

Appellant has not challenged either the admissibility or the reliability of the testimony of the witness Ludden, the pharmacist who, on June 1, 1942, filled (and many times afterward refilled) the prescription for nitroglycerine tablets which were to be taken for "heart pain" [R. 401].

The uncontradicted testimony of the pharmacist that the insured complained of pain in his chest and desired the prescription *"as soon as possible"* [R. 88] sufficed to prove the falsity of the material representation in the application that insured had never suffered from pain or pressure in the chest. The fact that insured was taking

medicine for the relief of heart pains and submitting to repeated examinations and electrocardiographic studies proved, beyond all reasonable doubt, that he knew of his condition.

Conclusion.

Appellee submits that the judgment under review is sustained by well settled rules of law, and that appellant has failed entirely to show error in any particular. Therefore, the judgment should be affirmed.

Respectfully submitted,

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